REQUEST FOR VACCINATION

Patient's name: _____

Date of birth: _____ EDC: _____

Dear Physician/Vaccine clinic:

This patient is currently pregnant and receiving obstetrical care in my office. She needs the following vaccine, but I do not carry vaccines in my office.

The American College of Obstetricians and Gynecologists (ACOG) supports the Centers for Disease Control and Prevention's (CDC) recommendations for vaccination of pregnant women. I have counseled the patient about the risks, benefits, alternatives, and indications of the vaccine(s) during pregnancy. She understands the risks and benefits to herself and her fetus, and has chosen to receive the vaccination(s).

I recommend that she receive the following vaccination(s). Please provide her with the following:

- ☐ Inactivated Influenza Vaccine Date administered: _____
- ☐ Hepatitis A Vaccine Date administered: _____
- ☐ Hepatitis B Vaccine Date administered: _____
- ☐ Tetanus/Diphtheria Date administered: _____
- ☐ _____ Date administered: _____

I would appreciate it if you could fill out the dates administered on this form and fax it to my office at the number listed below. Thank you very much for your assistance.

Sincerely,

Attention: _____

Fax Number: _____